CYNTHIA L. POST, PH.D.
301-587-7551

PATIENT INFORMATION

PROVIDER:	APPOINTMENT DATE:	TIME:

PATIENT NAME:	DATE OF BIRTH:	AGE:

HOME ADDRESS:	CITY:	STATE:	ZIP:

OCCUPATION:	SOCIAL SECURITY NO.:	SEX:	MARITAL STATUS:	HOME PHONE:

EMPLOYER:	EMPLOYER'S ADDRESS:	WORK PHONE:

NEAREST RELATIVE:	RELATIONSHIP:	HOME PHONE:	WORK PHONE:

REFERRED BY:	REFERRAL'S PHONE:	PRIMARY PHYSICIAN:	PRIMARY'S PHONE:

BILLING INFORMATION (Fill in this section **ONLY** if Financially Responsible Person is **NOT** the patient.)

NAME: (Different from patient)	RELATIONSHIP:	HOME PHONE:

ADDRESS: (If different from patient)

INSURANCE INFORMATION

PRIMARY: (INSURANCE COMPANY'S NAME)	SUBSCRIBER'S NAME:	INSURANCE COMPANY PHONE:

DATE OF BIRTH	SOCIAL SECURITY NO.:	ID/POLICY NO.:	GROUP NO.:

SECONDARY:(INSURANCE COMPANY'S NAME)	SUBSCRIBER'S NAME:	INSURANCE COMPANY PHONE:

DATE OF BIRTH	SOCIAL SECURITY NO.:	ID/POLICY NO.:	GROUP NO.:

EMPLOYER:	EMPLOYER'S ADDRESS:	WORK PHONE:

Insurance and the Payment of Medical Bills: Professional services are rendered to the patient and therefore charged to the patient, not to an insurance company. The billing office can help you file an insurance claim but I cannot accept responsibility for collecting the insurance claim or for negotiating a settlement on a disputed claim. If your account has a balance due, you will receive a monthly statement. You are responsible for payments on your account for any past due balance and may be charged additional fees if collection activity is necessary for me to collect those balances. I will try to help you with questions that may arise concerning your insurance. **Appointment not cancelled 24 hours prior to the session will be charged in full to the patient.**

PATIENT'S AUTHORIZATION

I hereby authorize Cynthia L. Post, Ph.D. to apply for benefits on my behalf for covered services rendered. I request payment be made directly to Cynthia L/ Post, Ph.D. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:	DATE: